

Thank you for choosing our dental team. To help us meet all your Healthcare needs please fill form out completely. Sign & Print form to bring to our office - Thank you!

Patient Information (confidential)

First Name _____ Last Name _____
MI _____ Preferred Name (If different from above) _____
Address _____
City, State, Zip _____
Home Phone _____ Work Phone _____ Ext _____
Cell Phone _____ Text Message for appt reminders Yes No
E-mail address for appointment reminders _____
Birth Date _____ Social Security # _____ Driver's Lic # _____
Sex Male Female Employer _____
Marital Status: Married Single Divorced Separated Widowed
Referred By _____
Date of Last Cleaning _____ Previous Dentist _____
Primary Physician _____ Phone Number _____
Emergency Contact _____ Phone Number _____

Responsible Party

Name of Responsible party _____
Relationship to patient _____ Social Sec# _____
Birthdate _____ Driver's License # _____
Address (If different from above) _____
City, State, Zip _____
Home Phone _____ Work Phone _____ Ext _____
Cell Phone _____ E-mail address _____

Insurance Info

Name of Insured _____
Birthdate _____ Soc Sec # _____ Employer _____
Insurance Company _____ Group Number _____
Insurance company address _____

Medical History

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medications that you may be taking, could have an important interrelationship with the dentistry you receive.

Thank you for answering the following questions.

Are you under a physicians care now? yes no If yes explain: _____
Have you ever been hospitalized? yes no If yes explain: _____
Have you ever had a head or neck injury? yes no If yes explain: _____
Are you taking any medications? Please list: _____
Have you ever taken Phenfen or Redux? yes no When? _____

Are you on a special diet? yes no If yes explain: _____
 Do you use tobacco? yes no
 Do you use controlled substances? yes no If yes explain: _____

Women: Are you

Pregnant/Trying to get pregnant? Nursing? Taking oral Contraceptives?

Are you allergic to any of the following

Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics Other _____

If yes please explain: _____

Do you have, or have you had any of the following?

- | | | |
|--|--|--|
| <input type="checkbox"/> AIDS/HIV positive | <input type="checkbox"/> Frequent Diarrhea | <input type="checkbox"/> Renal Dialysis |
| <input type="checkbox"/> Alzheimer's Disease | <input type="checkbox"/> Frequent Headaches | <input type="checkbox"/> Rheumatism |
| <input type="checkbox"/> Anaphylaxis | <input type="checkbox"/> Genital Herpes | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Shingles |
| <input type="checkbox"/> Arthritis/Gout | <input type="checkbox"/> Heart Attack/Failure | <input type="checkbox"/> Sickle Cell Disease |
| <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Sinus Trouble |
| <input type="checkbox"/> Artificial Joint | <input type="checkbox"/> Heart Pace Maker | <input type="checkbox"/> Spina Bifida |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart Trouble/Disease | <input type="checkbox"/> Stomach/Intestinal Disease |
| <input type="checkbox"/> Blood disease | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Hepatitis A | <input type="checkbox"/> Swelling of Limbs |
| <input type="checkbox"/> Breathing Problem | <input type="checkbox"/> Hepatitis B or C | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Bruise Easily | <input type="checkbox"/> Herpes | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Hives or Rash | <input type="checkbox"/> Tumors or Growths |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Cold Sores/Fever Blisters | <input type="checkbox"/> Irregular Heartbeat | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Congenital Heart Disorder | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Yellow Jaundice |
| <input type="checkbox"/> Cortisone Medicine | <input type="checkbox"/> Leukemia | <input type="checkbox"/> Gums that bleed when you brush
your teeth? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Gums are red, swollen or tender <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> Drug Addiction | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Gums have pulled away (receded) from
teeth? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> Easily Winded | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Pus Between teeth and Gums when
gums are pressed? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Permanent teeth are loose or
separating? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> Epilepsy or Seizures | <input type="checkbox"/> Pain in Jaw | <input type="checkbox"/> Persistent bad breath? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Parathyroid Disease | |
| <input type="checkbox"/> Excessive Thirst | <input type="checkbox"/> Psychiatric Care | |
| <input type="checkbox"/> Fainting Spells | <input type="checkbox"/> Radiation Treatments | |
| <input type="checkbox"/> Frequent Cough | <input type="checkbox"/> Recent Weight Loss | |

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent, or Guardian _____ Date _____